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Original Research Article

Coverage and compliance of mass drug administration against lymphatic filariasis in Kalaburgi district

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ABSTRACT

Background: Lymphatic filariasis (LF) is endemic in 83 countries and territories, with more than a billion people at risk of infection. Filariasis has been a major public health problem in India next only to malaria. Study was done to assess coverage and compliance of mass drug administration (MDA) against lymphatic filariasis in Kalaburgi districts.
Methods: This cross-sectional coverage evaluation survey was done in one urban and three rural clusters in district. The data was compiled, tabulated and analyzed using proportions.
Results: A total of 791 subjects were interviewed, male subjects constituted about 47.7%. Majority of the subjects were in the age group of 16-60 years (69.9%), while only 3.2% were in <2years. 82.9% persons have received the drugs. Out of the 530 persons who have received the drugs, 86.9% persons have consumed the drugs. Only 59.9% of study subjects consumed tablets in front of health workers. A total of 69 subjects have not consumed tablets, 20.3% said told fear of side reaction, and 20.3% subjects said they don't have faith in tablet. Only 11 persons suffered from vomiting and nausea.
Conclusions: There is an urgent need for more effective drug delivery strategies and also proper IEC should be done to educate and to improve the coverage and compliance in the districts.

Keywords: Lymphatic filariasis, Mass drug administration, Coverage, Compliance, Diethylcarbamazine, Kalaburgi

INTRODUCTION

Lymphatic filariasis (LF) is one of the important public health and socioeconomic problem faced by many developing countries in the world.[1] It is endemic in 83 countries and territories, with more than a billion people at risk of infection. Nearly 120 million people are affected worldwide of whom about 40 million are incapacitated and disfigured by the disease. It is one of the world's leading causes of permanent and long-term disability with an estimated 5.1 million disability adjusted life years (DALYs) are lost due to this disease.[2,3] The most practical and feasible method of controlling LF is rapid reduction of microfilaria load in the community by annual mass drug administration (MDA) of a single dose of diethylcarbamazine (DEC). [4] Large scale chemotherapy plays a vital role in the control of many parasitic diseases.[5] Recent research studies showed that annual single-dose MDA with diethylcarbamazine (DEC) is an effective tool for the control of LF and 5-10 rounds of treatment with 75-80% coverage could possibly eradicate it by reducing the transmission to very low levels.[6] The Government of India (GOI) in 2004 began a nationwide MDA campaign in all the known LF endemic districts with an annual single dose of DEC with the aim of eliminating it as a public health problem by the year 2015 according to National Health Policy 2002.[7] World Health Organization has recommended single-dose DEC and albendazole as a preferred combination for repeated,

annual MDA in filariasis endemic areas, which reduces blood microfilaria (MF) counts.[8,9]

The World health Assembly targeted lymphatic filariasis for elimination mainly through a strategy of mass drug administration (MDA). The effectiveness of the lymphatic filariasis elimination depends on upon the consumption of the recommended drug by the affected population. However, implementation of MDA led to diverse problems in some communities (urban areas, remote areas, migrant population and minority groups), with high rates of non-compliance having caused low treatment coverage. Although, MDA alone has been shown to suppress transmission of lymphatic filariasis in many areas where it has been implemented, it is often accompanied by resurgence once there is residual infection in the population. Therefore, sustainability of transmission suppression of lymphatic filariasis could be achieved only through integration of different strategies of vector control along with MDA. Besides, monitoring of the success of the lymphatic filariasis elimination programme depends on entomological studies of the mosquito vectors that transmit the disease in endemic communities.[10] Hence, this survey was done to assess the coverage and compliance of MDA in Kalaburgi district.

METHODS

There are 7 taluks in the district, as per the guidelines, four sites have to be selected. One among them is urban. Kalaburgi city is selected for urban. The sites were arranged in the descending order of the coverage of MDA. It was decided to select an average performed area and Khanapur was selected as urban site from Kalaburgi. There are 80 primary health centers in the rural part of the district. In order to select three sites, the PHC's have been classified into three strata, that is, mutually exclusive and exhaustive groups. It is based on the coverage of 13th round of MDA. The primary health centers are arranged according to the coverage, as reported, in descending order. The width of the class interval of each stratum is made equal, that is divided by three, works out to be 19. The three strata, along with class intervals, were high (100-119), medium (80-99) and low (60-79) performance. From each stratum, one PHC is selected randomly using the MS excel worksheet. The respective selected PHC's were K. Hipparga in Chittapur taluk, Kamalapur in Kalburgi rural taluk and Madana in Sedam taluk. In the selected primary health centers, the sub centers (SC) under the PHC were arranged in descending order of the coverage. The high performance SC in the first group is selected and the middle one is selected in the second one and the poor performance SC is selected in the third one. This selection is made giving the weight to the performance of each SC's. A village is selected from each of the sub center randomly. The households in the villages were contacted and the details were collected as per the pre-designed schedule. The population to be contacted was fixed at a minimum of 150 in each site, so that the total coverage should be at least 600. The study was carried out during September 2016 to October 2016.

Collection of data at village level

The team of investigators visited PHC's and then selected sub centers. They interacted with the concerned drug distributors in the selected SCs as well as the medical officers of the PHC's. Investigators visited the selected villages and with the help of drug distributors collected the required information from the residents of the villages. In total, 140 houses were visited during the survey, with a minimum of 29 houses in each of the cluster. The data were collected in the pre designed and structured questionnaire and were entered in the excel sheet for processing.

RESULTS

A total of 791 subjects were interviewed. The overall coverage of MDA in Kalaburgi district was 86.1% and compliance rate was 86.7%. Male subjects constituted about 47.7% and female 52.3%. Majority of the subjects were in the age group of 16-60 years (69.9%), while only 3.2% were in <2years (Table 1).

Table 1: Age-gender wise distribution of study subjects.

Age (in years)	Male (%)	Female (%)	Total (%)
<2	14 (53.8)	12 (46.2)	26 (100.0)
2-15	91 (55.8)	72 (44.2)	163 (100.0)
16-60	246 (44.5)	307 (55.5)	553 (100.0)
60 and above	26 (53.0)	23 (47.0)	49 (100.0)
Total	377 (47.7)	414 (52.3)	791 (100.0)

*Figures in bracket are percentages.

Out of the 791, 656 (82.9%) persons have responded that they had received the drugs (Table 2).

Table 2: Distribution of study subjects based on whether they had received drugs.

Received drugs	Number	Percentage (%)
Yes	530	80.7
No	127	19.3
Total	656	100.0

Table 3: Distribution of study subjects based on whether they had consumed drugs.

Consumed drugs	Number	Percentage
Yes	461	86.9
No	69	13.1
Total	530	100.0

Out of the 530 persons who have received the drugs, 461 (86.9 %) persons have responded that they have consumed the drugs (Table 3). Only 59.9% of study subjects consumed tablets in front of health workers (Table 4). A total of 69 subjects not consumed tablets, 27.6% were out of station, 20.3% told fear of side reaction, and 20.3% subjects said they don't have faith in tablet (Table 5). 11 persons suffered from vomiting and nausea and 9 persons got fever (Table 6).

Table 4: Consumption of tablets in presence of drug distributor.

Consumed	Number	Percentage (%)
DOTS	276	59.9
Non-DOTS	185	40.1
Total	461	100.0

Table 5: Distribution of subjects based on the reasons for non-consumption.

Reason for non-consumption	Frequency	Percentage (%)
Drug distributor not visited	02	2.9
Out of station	19	27.6
Fear of side reaction	14	20.3
No faith in drug distributor	1	1.4
No faith in tablets	14	20.3
Suffering from chronic disease other than filarial	4	5.8
Others	15	21.7
Total	69	100.0

Table 6: Distribution of subjects based on the occurrence of side effects.

Side effect	Frequency	Percentage (%)
Nausea, vomiting	11	44.0
Fever	9	36.0
Others	5	20.0
Total	25	100.0

DISCUSSION

In our survey a total of 791 people were interviewed. The overall coverage of MDA in Kalaburgi district was 86.1% and compliance rate was 86.7%. The percentages of male and female population of the study were 47.7% and 52.3% respectively. Out of the 791, 530 (67.0%) persons have responded that they had received the drugs. Out of the 530 persons who had received the drugs, 461 (86.9%) persons have responded that they had consumed the drugs. Only about 59.9% of the surveyed population has consumed in presence of the health worker.

Study by Patel in Kalaburgi district in year 2010 shows coverage rate of 39%. Majority of the respondents were in the age group of 15-59 years (63.9%), main reason for not taking drug was fear of side effects (51.2%) and did not receive tablets (15.2%). Only 2.3% actually experienced side effects.[11] Mukhopadhyay et al study in five districts of Andhra Pradesh shows 69.96% persons received DEC tablets and 64.64% actually consumed during MDA programme. Maximum coverage and consumption of DEC tablets during MDA programme was noted from East Godavari district as 94.57 and 76.06% respectively.[12] Babu et al study in Orissa in 2002 shows coverage rate 67.05% and 41.57% of compliance. The predominant reason for not receiving drugs was that the health worker or drug distributor did not visit the family (75.8%), followed by 'absence of family members'(7.5%), 'felt unnecessary' (6.6%), 'fear of side-effects'(4.4%).[13] Lahariya et al study shows compliance rate in the range of 60–70% in 3 districts.[14]

CONCLUSION

The overall coverage of MDA in Kalaburgi district was 86.1% and compliance rate was 86.7%. Reporting system need to be refined to get the tabulated registered data right from the village level to PHC, taluk and district level. The observation of supervisors appointed for MDA need to be brought under the daily activity schedule and to be monitored at PHC/district level to have concurrent/consecutive supervision. The staff employed for MDA may be trained to follow DOT and it may be monitored concurrently by the supervisors. The best IEC activity for MDA is inter-personnel communication. So this process may be made regular one in all the endemic pockets supportive control measures such as anti-larval work can be initiated to bring down the vector density so as to avoid transmission.

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REFERENCES

1. Krentel A, Fischer P, Manoempil P, Supali T, Servais G, Rückert P. Using knowledge, attitudes and practice (KAP) surveys on lymphatic filariasis to prepare a health promotion campaign for mass drug administration in Alor District, Indonesia. Trop Med Int Health. 2006;11:1731-40.
2. World Health Organization. Life in the 21 st century: A vision for all. The World Health Report 1998. Available at: http://www.who.int/whr/1998/ en/whr98 en.pdf. Accessed on 29 April 2017.
3. World Health Organization. Regional strategic plan for elimination of Lymphatic Filariasis (2004-2007) 2004; 1-2. Available at: apps.searo.who.int/pdsdocs/ B0207.pdf. Accessed on 30 April 2017.
4. Das PK, Ramaiah KD, Augustine DJ, Kumar A. Towards elimination of lymphatic filariasis in India. Trends Parasitol. 2001;17:457–60.
5. Savioli L, Crompton DWT, Ottesen EA, Montresor A, Hayashi S. Intestinal worms beware: development in antihelminthic chemotherapy usage. Parasitol Today. 1997;13:43–4.
6. Ottesen EA, Ismail MM, Horton J. The role of albendazole in programmes to eliminate lymphatic filariasis. Parasitol Today. 1999;15:382-6.
7. National Health Policy 2002. New Delhi: Ministry of Health and Family Welfare, Government of India 2002: 1-39.
8. World Health Organization. Preparing and implementing a national plan to eliminate Lymphatic filariasis in countries where Onchocerciasis is not co-endemic. Available at: http://whqlibdoc.who.int/hq/2000/WHO_CDS_CPE _CEE_2000.15.pdf. Accessed on 25 April 2017.
9. El Setouhy M, Ramzy RM, Ahmed ES, Kandil AM, Hussain O, Farid HA, et al. A randomized clinical trial comparing single- and multi-dose combination therapy with diethylcarbamazine and albendazole for treatment of bancroftian filariasis. Am J Trop Med Hyg. 2004;70:191-6.
10. Dogara M, Nock H, Agbede R, Ndams S, Joseph K. Entomological survey of mosquitoes responsible for the transmission of Lymphatic Filariasis in three endemic villages of Kano State, Nigeria. Int J World Health Societal Politics. 2012;7:2:1-6.
11. Patel PK. Mass drug administration coverage evaluation survey for lymphatic Filariasis in Bagalkot and Gulbarga districts. Indian J Community Med. 2012;37:101-6.
12. Mukhopadhyay AK, Patnaik SK, Satya Babu P, Rao KNMB. Knowledge on lymphatic filariasis and mass drug administration (MDA) programme in filaria endemic districts of Andhra Pradesh, India. J Vector Borne Dis. 2008;45:73–5.
13. Babu BV, Kar SK. Coverage, compliance and some operational issues of mass drug administration during the programme to eliminate lymphatic filariasis in Orissa, India. Tropical Med Int Health. 2004;9(6):702–9.
14. Lahariya C, Mishra A. Strengthening of mass drug administration implementation is required to eliminate lymphatic filariasis from India: an evaluation study. J Vector Borne Dis. 2008;45:313–20.

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